

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-020550

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 162

Primary Registration District No. 559s

Registrar's No. 50

FILED MAY 17 1963

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jefferson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Imperial</b>		c. CITY OR TOWN <b>Imperial</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rt.3 Box 458</b>		d. STREET ADDRESS <b>Rt 3 Box 458 Old Lemay Ferry Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>---</b> Last <b>Ehlen</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-1888</b>
9. AGE (last birthday) <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (City and state or country) <b>Prarie Du Rocher, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>Frank England</b>		13b. MOTHER'S MAIDEN NAME <b>Unown Batchelor</b>	
14. NAME OF HUSBAND OR WIFE <b>John</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Wm. Gebhardt Rt. 3 Box 458 Imperial, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Middle Cerebral artery thrombosis</b> DUE TO (b) <b>Cerebral Arterial Sclerosis</b> DUE TO (c) <b>5 yrs</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>31 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>D. infectio Millitum 20 yrs.</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>---</b> a.m. <b>---</b> p.m. <b>---</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Imperial</b> COUNTY <b>Jefferson</b> STATE <b>Mo.</b>	
21. I attended the deceased from <b>10/9/61</b> to <b>5/19/63</b> and last saw her alive on <b>5/19/63</b>		Death occurred at <b>11.15 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Charles Buonside MD</b> (Degree or title)		22b. ADDRESS <b>2069 W. Argonne Rushmore</b>	
22c. DATE SIGNED <b>5/10/63</b>		22d. LOCATION (City, town, or county) <b>Imperial</b> (State) <b>Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>May 13, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cemetery</b>	
24. FUNERAL DIRECTOR <b>C. Hoffmeister Mortuaries</b> ADDRESS <b>7814 S. Broadway</b>		25. DATE RECD. BY LOCAL REG. <b>5-15-63</b> 26. REGISTRAR'S SIGNATURE <b>Robert E. Bauer</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

MAV 27 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James C. Hoffmeister*

Licensed Embalmer No. 3871

P. O. Address

7814 S. Broadway

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting:

If this body is not embalmed, fact should be so stated above.

Ar. Elias Burnside 206 W. Argentine, Kankakee  
TA-1-1956